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RAPID RESPONSES FROM  
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As of November 19, 2003, this paper had generated 28 Rapid Responses, which can be read in their entirety at <http://bmj.bmjournals.com/cgi/eletters/327/7414/536>.

Following are edited excerpts.—Editor

Beich and colleagues' study is an example of the prevention paradox, that few patients personally benefit from preventive interventions. Although there are fewer studies [demonstrating] that brief alcohol interventions change patients' health outcomes than [there are] in pharmacotherapy for cholesterol, screening for alcohol problems is neither more nor less caught in that paradox.

Daniel C Vinson *professor*  
University of Missouri-Columbia

Two of the 8 studies that form part of the meta-analysis were mine (Scott and Anderson 1990, Anderson and Scott 1992). There are substantive errors in the numbers extracted from these studies and reported by the authors in tables 1, 2, and 3.... The authors confuse research studies with normal practice, which affects their estimates of the screening effect, thus leading to flawed conclusions.... But even without these errors, the conclusions by the authors are based on other erroneous assumptions....

Health screening in general practice is not just about alcohol. It is about smoking, overweight, raised blood pressure, etc. So the utility of screening has to be based on broader assumptions. A general practice can target its methods of screening to particular population groups or at particular times, such as new patient registration, which might decrease its workload and increase its efficiency.

It is not correct to state that screening is not an effective precursor to brief interventions, without either undertaking cost-effectiveness analysis or comparing it to other health interventions. In terms of health gain, screening and brief interventions for hazardous/harmful alcohol use might be a very cost-effective intervention. No information is given about this.

Peter Anderson *independent consultant in public health*  
Nijmegen University  
Netherlands

[I]t is good medical practice to support health-promoting activities. One example is the "teachable moment" for alcohol misuse. This uses the presenting complaint to the emergency room, eg, fall, collapse, head injury, assault, accident, as the "learning opportunity."

Thereby patients may start to develop insight into the consequences of their drinking behavior. Brief intervention is reported to be effective in the ER following injury, especially when carried out by alcohol health workers secondary to initial detection by the medical or nurse practitioner dealing with the patient's presenting complaint.

Robin Touquet *emergency department consultant*

St Mary's Hospital, London, UK  
Robert Patton, Michael Crawford, and  
James S Huntley

We question the rationale of using data extracted from studies aimed at assessing the efficacy of brief intervention to conclude on the effectiveness of the screening procedure. In studies designed to evaluate the efficacy of a therapeutic intervention, it is important to ensure internal validity, and thus, inclusion and exclusion criteria have to be restrictive. For instance, in order to guarantee a high proportion of follow-up data, subjects are required to have a stable home address, provide significant others' addresses, and speak the official trial language. Some of the brief intervention trials excluded patients who had received advice to cut down on drinking in the last 6 months or the last year. Nevertheless, their exclusion could not be considered as lack of efficacy of the screening process.

Jean-Bernard Daeppen  
Alcohol Treatment Center  
Lausanne, Switzerland  
Nicolas Bertholet, Bernard Burnand

Beich et al report figures which are very discouraging in relation to screening and brief alcohol intervention. However, their technically excellent results do not take into account that in real life situations 1) patients do not have to sign informed consents and participate in studies, which presumably makes them more receptive to intervention; 2) they may (after intervention) reduce their drinking even though the amount is not big enough to classify them as "successful" according to the scientifically strict criteria used in Beich et al's analysis, but in which a reduction may be meaningful in the process of changing behavior or in preventing alcohol-related harm; and 3) a smaller reduction may additionally have an impact on other alcohol-related symptoms, eg, depression.

Kaija Seppä *professor*  
University of Tampere, Finland  
Mauri Aalto

Universal screening with validated instruments is much better for identifying patients with alcohol problems than any currently known alternative. And the data summarized by Beich et al support

the notion that brief intervention after screening is efficacious. Pragmatic trials and cost-effectiveness analyses in the future will likely find that alcohol screening followed by brief intervention is effective and cost-effective, much like other medical conditions routinely identified by screening. I do agree with Beich et al that these data are needed, and that even when they are available, we will find that many people need to be screened in order to benefit a few (as is true for most preventive interventions). Selective screening is a possible option but unlikely to be the best choice, since risky drinking is best identified before consequences that would cause selective screening to occur. Scientists can respectfully disagree about the implications of valid results. The discussion about this paper seems to be just that kind of disagreement. Until further data are available for alcohol screening and intervention (cost-effectiveness analyses and effectiveness trials), I respectfully disagree with the conclusions drawn by Beich et al and see no reason for recommendations for universal screening to change.

Richard Saitz *associate professor*  
Boston Medical Center and Boston University

From the authors of the study:

[Much of] the real disagreement with our paper is about the interpretation of the result of our meta-analysis rather than about the results as such. Among the responses to our meta-analysis we have not yet seen any substantial arguments against our conclusion that seen from the consultation room, screening is at best a low-effective and not very attractive alternative for excessive drinking case-finding. Before any reasonable cost-effectiveness calculations can be made, we suggest that screening-based programs should be compared to a patient-centered clinical approach like the one taking place already....

We strongly recommend that general practitioners respond to all complaints or symptoms in which alcohol is likely to be an etiologic agent or likely to act as a barrier to treatment or to solutions to problems. These clinically appropriate occasions are innumerable. The fact that only a few minutes of advice is sometimes helpful, even in some patients approached by trial screening, should in our opinion encourage physicians to raise the subject when ever appropriate. To include screening in the recommendations remains unwarranted, in our opinion.

Anders Beich *research fellow*  
University of Copenhagen, Denmark  
Thorkil Thorsen